OASIS Burden Reduction Web cast and Satellite Broadcast –
Handout Package –

Topic 4: OASIS Diagnosis Reporting
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Graphic 1:

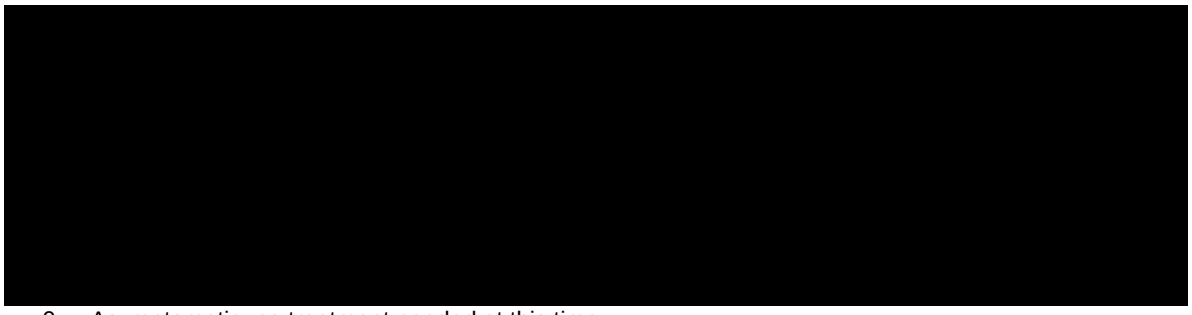
What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996

- Abbreviated as HIPAA
- Compliance with ICD-9-CM is required under HIPAA

Graphic 2:

(M0230/M0240) Diagnoses and Severity Index: List each medical diagnosis or problem for which the patient is receiving home care and ICD-9-CM code category (three digits required; five digits optional – no surgical or V-codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for Severity Rating



0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled, history of rehospitalizations

	(M0230) Primary Diagnosis	ICD-9-CM	Severity Rating				
a.	_____	(__ __ __ . __ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
	(M0240) Other Diagnoses	ICD-9-CM	Severity Rating				
b.	_____	(__ __ __ . __ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
c.	_____	(__ __ __ . __ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
d.	_____	(__ __ __ . __ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
e.	_____	(__ __ __ . __ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
f.	_____	(__ __ __ . __ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Graphic 3:

Definition of Primary and Secondary Diagnosis

Primary, Diagnosis, (M0230)

- Diagnosis most related to the current Plan of Care;
- Logic for determining this diagnosis has not changed under HHPPS;
- Diagnosis may or may not be related to a patient's recent hospital stay;
- Diagnosis represents the most intensive skilled services

Secondary Diagnosis, (M0240)

- All conditions that coexisted at the time the POC was established;
- Conditions which developed subsequent to the established POC;
- Conditions which affect the treatment or care of the patient.
- Should include not only conditions actively addressed in POC but also any comorbidity affecting the patient's responsiveness to treatment.

Graphic 4:

V-Code General Principles

V-codes reported in OASIS:
Governed by the ICD-9-CM Official Guidelines for Coding and Reporting.
In home health setting, V-code used for patient with a current or resolving disease or injury encounters the health care system for a specific aftercare of that disease or injury.
Effective Oct. 1, 2003, utilized in OASIS as follows:

- V-code**, may be reported in M0230 or in M0240 (b) through (f);**
- V-code**, if replaces a case mix diagnosis in M0230, indicates optional reporting of M0245;**

V-codes **may not be entered in M0245(a) or (b)** as the case mix does not assign any points to V-codes.

Graphic 5:

Case Mix Diagnosis

Definition: A primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological or burns/trauma group for Medicare PPS case mix assignment.
Case Mix Diagnosis may involve manifestation coding.
V-codes cannot be used in case mix as there is no assignment of points to these codes.

Graphic 6:

Case Example #1 - Proposed M0230

(M0230) Primary Diagnosis	ICD-9-CM
a. Physical Therapy	(_V57 . 1 __)
(M0240) Other Diagnoses	ICD-9-CM
b. Abnormality of gait	(__ 781 . 2 __)

Graphic 7
Proposed M0245

Effective 10/1/2003

(M0245) **Payment Diagnosis (optional):** If a V-code was reported in M0230 in place of a case mix diagnosis, list the primary diagnosis and ICD-9-CM code, determined in accordance with OASIS requirements in effect before October 1, 2003--no V-codes, E-codes, or surgical codes allowed. ICD-9-CM sequencing requirements must be followed. Complete both lines a and b if the case mix diagnosis is a manifestation code or in other situations where multiple coding is indicated for the primary diagnosis; otherwise, complete line a only.

	(M0245) Primary Diagnosis	ICD-9-CM
a.	_____	(__ __ __ . __ __)
	(M0245) First Secondary Diagnosis	ICD-9-CM
b.	_____	(__ __ __ . __ __)

Graphic 8:

Case Example #3, Completion of M0245

(M0245) **Payment Diagnosis (optional): If a V-code was reported in M0230 in place of a case mix diagnosis, list the primary diagnosis and ICD-9-CM code, determined in accordance with OASIS requirements in effect before October 1, 2003--no V-codes, E-codes, or surgical codes allowed. ICD-9-CM sequencing requirements must be followed. Complete both lines a and b if the case mix diagnosis is a manifestation code or in other situations where multiple coding is indicated for the primary diagnosis; otherwise, complete line a only.**

	(M0245) Primary Diagnosis	ICD-9-CM
a.	**Abnormality of Gait**	(**7 8 1 . 2** __)
	(M0245) First Secondary Diagnosis	ICD-9-CM
b.	_____	(__ __ __ . __ __)

Graphic 9

ICD-9-CM Coding Criteria for Surgical Wounds

Clinician must look at the origin of the wound in order to determine if the wound is a surgical wound or not.
If surgery created the wound then the wound is a surgical wound.
If the wound condition existed prior to a surgical procedure and;
If the wound remains following the surgical procedure then the wound is coded as the type of wound that existed prior to the surgical procedure.
Examples:
#1). A patient's blister required an Incision and Drainage; the wound is coded as a blister.
#2). A patient was hospitalized for an Appendectomy and was discharged from the hospital with a surgical wound; the wound is coded as a surgical wound.

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1. GENERAL DIAGNOSIS CODING PRINCIPLES AND CODING ISSUES SPECIFIC TO M0230

The logic for determining the primary (first listed) diagnosis for M0230 remains unchanged under the Medicare home health prospective payment system (PPS). Determine the primary diagnosis based on the condition most related to the current plan of care. The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the HHA. Skilled services (skilled nursing, physical, occupational, and speech therapy) are used in judging the relevancy of a diagnosis to the plan of care and to OASIS item M0230.

If a patient is admitted for surgical aftercare, list the relevant medical diagnosis only if it is still applicable. If it is no longer applicable (e.g., the surgery eliminated the disease or the acute phase has ended), then a V code, such as for surgical aftercare, is generally appropriate as the primary diagnosis. The importance of this principle can be seen in the example of hospitalization for the surgical repair of a hip fracture. Coding guidelines stipulate that the acute fracture code may only be used for the initial, acute episode of care, which is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care.

V codes cannot be used in case mix group assignment. Effective October 1, 2003, if a provider reports a V code in M0230 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0245. You must select the code(s) that would have been reported as the primary diagnosis under the original OASIS-B1 (8/2000) instructions that did not allow V codes. The CMS web site contains additional guidelines for diagnosis reporting under PPS at: http://www.cms.hhs.gov/prodocs/hhdiag.pdf.

2. MANIFESTATION CODES

In certain cases, ICD-9-CM requires more than one code to report a condition. This requirement, termed "multiple coding of diagnoses," often involves both a disease and one of its manifestations. The ICD-9-CM manual clearly shows the instances where manifestation coding is required.

- Manifestation coding affected some of the PPS case mix system's diagnosis groups.

- The PPS Final Rule listed certain manifestation codes carrying points under the case mix system. See the PPS Final Rule published July 3, 2000 on the CMS web site at: http://www.cms.hhs.gov/providers/hhapps/hhppsfr.asp.

- The manifestation codes must appear with all required digits in their proper sequence as the first secondary diagnosis.

- Do not report any code except the underlying cause of the manifestation in the position immediately preceding the manifestation code.

- Effective October 1, 2003, a V code may be determined to be the primary diagnosis in place of a disease and one of its manifestations. In that case, a single V code is listed as the primary diagnosis instead of the first two listed codes. However, the underlying condition may still be listed as a secondary diagnosis, if it meets the requirements for a secondary diagnosis.

3. GENERAL DIAGNOSIS CODING PRINCIPLES AND CODING ISSUES SPECIFIC TO M0240

- Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care."

- In general, M0240 should include not only conditions actively addressed in the plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

- Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome.

4. V CODE GENERAL PRINCIPLES

- The use of V codes is governed by the ICD-9-CM Official Guidelines for Coding and Reporting.

- If the patient has an acute condition relevant to the plan of care, continue to report the code for the acute condition. Whether it is listed as a primary or secondary diagnosis depends on the focus of care indicated on the plan of care. V codes are intended to deal with circumstances other than the diseases or injuries classifiable to the main part of ICD-9-CM (codes 001-999). For example, V codes are recorded as reasons for encounters with a health care provider.

- V codes may be used as the primary or secondary diagnoses.

- The major use of V codes in the home health setting occurs when a person with current or resolving disease or injury encounters the health care system for specific aftercare of that disease or injury.

Case Example 1: M0230: V code used to designate specific aftercare.

An 85-year-old independent female fell in her home, sustaining a left hip fracture. An open reduction with internal fixation was performed seven days ago. The patient was discharged home where her sister now cares for her. The patient is non-weight bearing on left lower extremity but can perform supervised pivot transfers with contact guard assist in and out of bed. The physician orders the agency to provide physical therapy for gait training and exercise three times per week for four weeks.

ICD-9-CM coding: V57.1 physical therapy; 781.2 abnormality of gait.

Discussion: The treatment is directed at rehabilitation following the hip fracture and surgery, therefore, V57.1 is selected as the primary diagnosis. Coding guidelines stipulate that the acute fracture code may only be used for the initial, acute episode of care. The acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care. Abnormality of gait was selected as the first secondary diagnosis because it accurately describes her current condition and the need for therapy.

(M0230/M0240) Diagnoses and Severity Index: List each diagnosis and ICD-9-CM code at the level of highest specificity (no surgical codes) for which the patient is receiving home care. Rate each condition using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) E-codes (for M0240 only) or V-codes (for M0230 or M0240) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then M0245 Payment Diagnosis should be completed. Case mix diagnosis is a primary or first secondary diagnosis that determines the Medicare PPS case mix group.

	(M0230) Primary Diagnosis	ICD-9-CM
a.	Physical Therapy	(V 5 7 . 1)
	(M0240) Other Diagnoses	ICD-9-CM
b.	Abnormality of gait	(7 8 1 . 2)

Note that the V code used in M0230 replaces a case mix diagnosis that would be used for payment. Therefore, completion of is indicated for Medicare PPS payment.

5. E CODE GENERAL PRINCIPLES

- E codes classify external causes of injuries, poisonings, and adverse effects of drugs.
- E codes are used in addition to a code from one of the main chapters of ICD-9-CM and are never to be recorded as a primary diagnosis.
- E codes may not be entered in M0230(a) or M0245.
- If an E code is reported, do not rate its severity.

Case Example 2: M0230/M0240: Multiple V codes.

An 80-year-old female is discharged from the hospital following surgical treatment for a malignant neoplasm of the colon, ICD-9-CM code 153.9, with exteriorization of the colon. The physician indicates that the patient will be undergoing chemotherapy for bowel cancer. Skilled nursing services are ordered for this patient 3 times a week for 6 weeks to teach colostomy care and to assess the patient's compliance with medications.

ICD-9-CM coding: V55.3, Instruction and care of colostomy; 153.9, Malignant neoplasm of the colon; and V58.42, Aftercare following surgery for neoplasm conditions classifiable to 140-239.

Discussion: The treatment provided by the home health agency is directed at the patient's colostomy care; therefore, V55.3 is more specific to the nature of the proposed services. Since the patient's physician indicated that the patient will undergo chemotherapy for bowel cancer, the malignant neoplasm diagnosis is added as a secondary diagnosis.

(M0230/M0240) Diagnoses and Severity Index:
List each diagnosis and ICD-9-CM code at the level of highest specificity (no surgical codes) for which the patient is receiving home care. Rate each condition using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) E-codes (for M0240 only) or V-codes (for M0230 or M0240) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then M0245 Payment Diagnosis should be completed. Case mix diagnosis is a primary or first secondary diagnosis that determines the Medicare PPS case mix group.

	(M0230) Primary Diagnosis	ICD-9-CM
a.	Instruction & care of colostomy	(V55.3)
	(M0240) Other Diagnoses	ICD-9-CM
b.	Malignant neoplasm of colon	(153.9)
c.	Aftercare following surgery for neoplasm	(V58.42)

The V code used in M0230 does not replace a case mix diagnosis in this example. Therefore, the agency **should not complete M0245**.

6. GENERAL DIAGNOSIS CODING PRINCIPLES AND CODING ISSUES SPECIFIC TO M0245.

M0245 Payment Diagnosis code is an optional OASIS item that home health agencies may use if a V code is selected in M0230 according to ICD-9-CM coding guidelines. M0245 is intended to facilitate PPS payment operations after October 2003 when a V code may be required as the primary diagnosis in place of certain diagnosis codes used to determine the PPS case mix group. This item will be inactive to prevent use until October 2003 and is shaded on the OASIS-B1 (12/2002) data set. Therefore, HHAs will not be able to enter this item in HAVEN or to transmit the data until the item is activated in October 2003.

Once M0245 is operational, if an HHA has entered a V code in M0230 in place of a case mix diagnosis, the HHA can then optionally enter the case mix diagnosis code in M0245.

a. **Complete M0245** if a V code has been reported in place of a home health PPS case mix diagnosis in M0230. To complete M0245, you must select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/200) instructions:

- No surgical codes - list the underlying diagnosis.
- No V codes or E codes - list the relevant medical diagnosis.
- If the patient's primary home care diagnosis is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in M0245(a) and the manifestation code should be entered in M0245(b).

Case Mix Diagnosis
Definition: A primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological or burns/trauma group for Medicare PPS case mix assignment.
Case Mix Diagnosis may involve manifestation coding.
V-codes cannot be used in case mix as there is no assignment of points to these codes.

ICD-9-CM Coding Criteria for Surgical Wounds
Clinician must look at the origin of the wound in order to determine if the wound is a surgical wound or not.
If surgery created the wound then the wound is a surgical wound.
If the wound condition existed prior to a surgical procedure and;
If the wound remains following the surgical procedure then the wound is coded as the type of wound that existed prior to the surgical procedure. The clinician is expected to refer to the patient's underling diagnosis when determining the proper ICD-9-CM code for the wound.

Case Examples of ICD-9-CM Coding Criteria for Wounds:
#1). A patient's blister required an Incision and Drainage; the wound is coded as a blister.
#2). A patient was hospitalized for an Appendectomy and was discharged from the hospital with a surgical wound; the wound is coded as a surgical wound.
#3). A patient's stasis ulcer required debridement, the wound is coded as a stasis ulcer

Case Example 3 (refer to Case Example 1): V code used in place of a case mix diagnosis in M0230. Completion of M0245 would be appropriate in this example:

An 85-year-old independent female fell in her home, sustaining a left hip fracture. An open reduction with internal fixation was performed seven days ago. The patient was discharged home where her sister now cares for her. The patient is non-weight bearing on left lower extremity but can perform supervised pivot transfers with contact guard assist in and out of bed. The physician orders the agency to provide physical therapy for gait training and exercise 3 times per week for 4 weeks.

Discussion: M0230 indicates V57.1, Physical Therapy, which was selected in place of 781.2, Abnormality of gait, which is a case mix diagnosis. Therefore, completion of M0245 would be indicated for payment. Abnormality of gait is used for M0245(a). No diagnosis is listed to M0245(b) because this is not a situation where multiple coding for the primary diagnosis is needed.

(M0245) Payment Diagnosis (optional): If a V-code was reported in M0230 in place of a case mix diagnosis, list the primary diagnosis and ICD-9-CM code, determined in accordance with OASIS requirements in effect before October 1, 2003--no V-codes, E-codes, or surgical codes allowed. ICD-9-CM sequencing requirements must be followed. Complete both lines a and b if the case mix diagnosis is a manifestation code or in other situations where multiple coding is indicated for the primary diagnosis; otherwise, complete line a only.

	(M0245) Primary Diagnosis	ICD-9-CM
a.	**Abnormality of Gait**	(**7 8 1 . 2**)
	(M0245) First Secondary Diagnosis	ICD-9-CM
b.		(.)

Do not complete M0245 if a V code has been reported in place of a diagnosis that is not a case mix diagnosis.

Case Example 4 (refer to Case Example 2): M0230: V code not in place of a case mix diagnosis.

An 80-year-old female is discharged from the hospital following surgical treatment for a malignant neoplasm of the colon, ICD-9-CM code 153.9, with exteriorization of the colon. The physician indicates that the patient will be undergoing chemotherapy for bowel cancer. Skilled nursing services are ordered for this patient three times a week for six weeks to teach colostomy care and assess the patient's compliance with medications.

ICD-9-CM coding: V55.3, Instruction and care of colostomy; 153.9, Malignant Neoplasm of the Colon; and V58.42, Aftercare following surgery for neoplasm conditions classifiable to 140-239.

Discussion: In this case example, V55.3 is not utilized in place of a case mix diagnosis. Therefore, the home health agency should not complete M0245.